

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G246 8-21-59 et

7988

CERTIFICATE OF DEATH

Reg. Dist. No.

07971

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUPE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>12 HRS.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAURE DE GRACE, MD</u>		d. STREET ADDRESS <u>1420 S. PHILA. BLVD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BOBBY</u> Middle <u>BOY</u> Last <u>ABNEY</u>		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/59</u>
9. AGE (In years lost birthday) yrs. <u>7</u>		IF UNDER 1 YEAR Months <u>12</u> Days <u>13</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>HAURE DE GRACE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>PAULINE OSBORN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SEAGENT HICKMAN - ABERDEEN, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INTRA UTERINE ANOXIA</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS.</u> <u>26 HRS.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/15, 1959</u> , to <u>7/15, 1959</u> , that I last saw the deceased alive on <u>7/15, 1959</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J. P. Ross</u> M.D. <u>200 N. UNION AVE</u>		PHYSICIAN'S NAME (Type) <u>I. R. ROSS, M.D.</u> <u>HAURE DE GRACE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony L. Frank</u>		ADDRESS <u>Harford County, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony L. Frank</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7989

CERTIFICATE OF DEATH

Reg. Dist. No. 07972

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles J Badders				4. DATE OF DEATH July 23 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6 1894	
9. AGE (In years, last birthday) 65 yrs.		IF UNDER 1 YEAR: Months 6 Days 18 Hours 15 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER				10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SMILEY S. BADDERS				14. MOTHER'S MAIDEN NAME ELIZABETH GIBBS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-26-8027		17. INFORMANT SAMUEL S. BADDERS Address WHITE HALL, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular DUE TO and renal disease (c) ?				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 21st, 1959 , to July 23rd, 1959 , that I last saw the deceased alive on July 23rd, 1959 , and that death occurred at 4:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				DATE SIGNED 7/23/59			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave. Havre de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/26/59		22c. NAME OF CEMETERY OR CREMATORY Ayres Chapel		22d. LOCATION (City, town, or county) (State) Dry Branch Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles B. Hunt ADDRESS Jarrettsville, Md.				24a. REC'D BY REGISTRAR JUL 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

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CERTIFICATE OF DEATH

928

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]	
DATE OF DEATH [Handwritten: 10/15/1918]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF DEATH [Handwritten: Home]	
CAUSE OF DEATH [Handwritten: Pneumonia]		MANNER OF DEATH [Handwritten: Natural]		PLACE OF BURIAL [Handwritten: St. Mary's Cemetery]	
SIGNATURE OF PHYSICIAN [Handwritten: J. Smith]		SIGNATURE OF MINISTER [Handwritten: W. Brown]		SIGNATURE OF CORONER [Handwritten: C. Green]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: E. White]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: F. Black]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: G. Gray]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: H. Hall]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: I. Hill]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: J. Jones]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: K. King]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: L. Lee]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: M. Martin]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: N. Nelson]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: O. Olson]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: P. Parker]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: Q. Quinn]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: R. Reed]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: S. Smith]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: T. Taylor]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: U. Underhill]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: V. Vance]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: W. Ward]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: X. Wright]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: Y. Young]		SIGNATURE OF JURY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Handwritten: Z. Zimmerman]		SIGNATURE OF JURY [Blank]	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07973

8012

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>		c. LENGTH OF STAY IN 1b <u>Entire life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Churchville</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Belle</u> Middle <u>Harward</u> Last <u>Baxter</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1867</u>
9. AGE (In years lost birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Harward</u>		14. MOTHER'S MAIDEN NAME <u>Harriet V. James</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Paul B. Harlan, Churchville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia of extensive gangrene over the sacral area</u> DUE TO (b) <u>Vascular thrombosis</u> DUE TO (c) <u>Generalized Arterio-sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>6 wks??</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>39</u> , to <u>July 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 26</u> , 19 <u>59</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Maryland</u> <u>July 27, 1959</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Rt. #2, Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster, Bel Air, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

2023

Reg. No. 10

1. PLACE OF DEATH Home		2. SEX Male	
3. AGE 78		4. RACE White	
5. DATE OF DEATH 10/15/2023		6. TIME OF DEATH 10:30 AM	
7. PLACE OF DEATH Home		8. CAUSE OF DEATH Natural Causes	
9. MANNER OF DEATH Natural		10. SIGNATURE OF DECEASED [Signature]	
11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF DECEASED [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF DECEASED [Signature]	
15. SIGNATURE OF DECEASED [Signature]		16. SIGNATURE OF DECEASED [Signature]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF DECEASED [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF DECEASED [Signature]	
23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF DECEASED [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF DECEASED [Signature]	
27. SIGNATURE OF DECEASED [Signature]		28. SIGNATURE OF DECEASED [Signature]	
29. SIGNATURE OF DECEASED [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF DECEASED [Signature]	
33. SIGNATURE OF DECEASED [Signature]		34. SIGNATURE OF DECEASED [Signature]	
35. SIGNATURE OF DECEASED [Signature]		36. SIGNATURE OF DECEASED [Signature]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF DECEASED [Signature]	
39. SIGNATURE OF DECEASED [Signature]		40. SIGNATURE OF DECEASED [Signature]	
41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF DECEASED [Signature]	
43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF DECEASED [Signature]	
45. SIGNATURE OF DECEASED [Signature]		46. SIGNATURE OF DECEASED [Signature]	
47. SIGNATURE OF DECEASED [Signature]		48. SIGNATURE OF DECEASED [Signature]	
49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF DECEASED [Signature]	
51. SIGNATURE OF DECEASED [Signature]		52. SIGNATURE OF DECEASED [Signature]	
53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF DECEASED [Signature]	
55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF DECEASED [Signature]	
57. SIGNATURE OF DECEASED [Signature]		58. SIGNATURE OF DECEASED [Signature]	
59. SIGNATURE OF DECEASED [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF DECEASED [Signature]	
63. SIGNATURE OF DECEASED [Signature]		64. SIGNATURE OF DECEASED [Signature]	
65. SIGNATURE OF DECEASED [Signature]		66. SIGNATURE OF DECEASED [Signature]	
67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF DECEASED [Signature]	
69. SIGNATURE OF DECEASED [Signature]		70. SIGNATURE OF DECEASED [Signature]	
71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF DECEASED [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF DECEASED [Signature]	
75. SIGNATURE OF DECEASED [Signature]		76. SIGNATURE OF DECEASED [Signature]	
77. SIGNATURE OF DECEASED [Signature]		78. SIGNATURE OF DECEASED [Signature]	
79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF DECEASED [Signature]	
81. SIGNATURE OF DECEASED [Signature]		82. SIGNATURE OF DECEASED [Signature]	
83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF DECEASED [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF DECEASED [Signature]	
87. SIGNATURE OF DECEASED [Signature]		88. SIGNATURE OF DECEASED [Signature]	
89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF DECEASED [Signature]	
93. SIGNATURE OF DECEASED [Signature]		94. SIGNATURE OF DECEASED [Signature]	
95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF DECEASED [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF DECEASED [Signature]	
99. SIGNATURE OF DECEASED [Signature]		100. SIGNATURE OF DECEASED [Signature]	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 1-101, SECTION 1-101.01, OF THE MARYLAND CODE, TITLE 1, SUBTITLE 10, OF THE MARYLAND ANNOTATED AND CODED STATUTES, AS AMENDED.

MEDICAL CERTIFICATION

VS A15 (4)
ISM 10/S7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8013 CERTIFICATE OF DEATH

07975

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b X Aberdeen Proving Ground,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Md		d. STREET ADDRESS Apt # 1 Bldg 2005 Aberdeen Proving Ground, Md	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle EMIL Last BOY		4. DATE OF DEATH Month July Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct 8, 1882
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio-Engineer		10b. KIND OF BUSINESS OR INDUSTRY Radio-Engineer	
11. BIRTHPLACE (State or foreign country) Alsace Lorraine		12. CITIZEN OF WHAT COUNTRY? Naturalized American citizen	
13. FATHER'S NAME Jean Boy		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Edmund G Boy (Son)		Address Apt #1 Bldg 2005 Aberdeen PG Md	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis adenocarcinoma of lung DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11 May , 19 59 , to 8 July , 19 59 , that I last saw the deceased alive on 8 July , 19 59 , and that death occurred at 3:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8 July 1959			
ACTUAL SIGNATURE D Hamaty Capt MC M.D.		US Army Hospital Aberdeen Proving Ground, Maryland	
PHYSICIAN'S NAME (Type) D HAMATY CAPT MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/10/59	22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Tarring Funeral Home		24a. REC'D BY REGISTRAR Jul 13 59	24b. REGISTRAR'S SIGNATURE Celine S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2013

Page 1 of 1

DECEASED

DATE OF DEATH

PLACE OF DEATH

DECEASED'S NAME

DATE OF BIRTH

PLACE OF BIRTH

DECEASED'S RESIDENCE

DATE OF DEATH

PLACE OF DEATH

DECEASED'S SEX

DECEASED'S AGE

DATE OF DEATH

PLACE OF DEATH

DECEASED'S OCCUPATION

DATE OF DEATH

PLACE OF DEATH

DECEASED'S CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED'S MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED'S SIGNATURE

DATE OF DEATH

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PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8014

CERTIFICATE OF DEATH

07976

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Darlington	
3. NAME OF DECEASED (Type or print) First Elena Middle N. Last Branham		4. DATE OF DEATH Month July Day 24 Year 19 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Elisha Willis		14. MOTHER'S MAIDEN NAME Ella Adcox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Samuel C. Branham,		Address Darlington Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) old age			INTERVAL BETWEEN ONSET AND DEATH 3-4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 12 , 19 59 , to July 24 , 19 59 , that I last saw the deceased alive on July 21 , 19 59 , and that death occurred at 11:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dudley Phillips MD		ADDRESS (Street, city or town, state) Darlington Md.	
DATE SIGNED 7/25/59			
PHYSICIAN'S NAME (Type) Dudley Phillips MD		Darlington, Md.,	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July, 27, 1959	22c. NAME OF CEMETERY OR CREMATORY Gel Glen Haven Memorial	22d. LOCATION (City, town, or county) Glen Burnie, Anne Arundel, Md., (State)
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McBrum		ADDRESS Abingdon, Maryland.	
24a. REC'D BY REGISTRAR JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 CERTIFICATE OF DEATH
 2011

NAME OF DECEASED: John D. Smith
 SEX: Male AGE: 78
 DATE OF BIRTH: Nov. 10, 1932
 PLACE OF BIRTH: Washington, D.C.
 U.S. CITIZENSHIP: Yes
 RACE: White
 RELIGION: Methodist
 OCCUPATION: Retired
 MARITAL STATUS: Married
 NAME OF SPOUSE: John D. Smith
 DATE OF DEATH: Nov. 10, 2011
 PLACE OF DEATH: Home
 CAUSE OF DEATH: Heart Disease
 MANNER OF DEATH: Natural
 SIGNATURE OF DECEASED: _____
 SIGNATURE OF WITNESSES: _____
 SIGNATURE OF PHYSICIAN: _____
 SIGNATURE OF FUNERAL DIRECTOR: _____
 SIGNATURE OF COUNTY CLERK: _____
 SIGNATURE OF STATE CLERK: _____

2 1
 R ATTENDING PH: _____ after death: Page 4
 IAN: The law requires that the death certificate be executed in 24 hours after death.
 RECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, should be filled with
 be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 of 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7991

CERTIFICATE OF DEATH

Reg. Dist. No. 07977

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or print) <u>Ernest Samuel BURLIN</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>A. P. Y. Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward K. BURLIN</u>				14. MOTHER'S MAIDEN NAME <u>Lina B. Shank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-05-5864</u>			
17. INFORMANT <u>Willard C. BURLIN</u>				Address <u>Coloma Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> DUE TO <u>Mitral Stenosis & Coagulation of Brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Adeno Carcinoma Prostate</u> (c) <u>3 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ o. m. _____ p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>58</u> , to <u>July 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 3</u> , 19 <u>59</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. H. Richards Jr.</u>				ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u> DATE SIGNED <u>7/3/59</u>			
PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-7-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vera Patterson & Son</u>				ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thompson</u>			

MEDICAL CERTIFICATION

or prior to burial, cremation, or removal, and in any event within 72 hours after death.

7992 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle L. Last BYRNE		4. DATE OF DEATH Month July Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses-Aid		10b. KIND OF BUSINESS OR INDUSTRY Hospital (APG.)	9. AGE (In years last birthday) yrs. 60
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Lewis		14. MOTHER'S MAIDEN NAME Hannah Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-22-0254	
17. INFORMANT John S. Byrne		Address 610 Walker St., Aberdeen Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Metastatic Carcinoma, both lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Breast DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 mos. 2 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 52 to 7-5-19 59 , that I last saw the deceased alive on 7-5-19 59 , and that death occurred at 2:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED ACTUAL SIGNATURE Peter P. Rodman, M.D. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D. Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/8/59	22c. NAME OF CEMETERY OR CREMATORY Lewis Family Cemetery	22d. LOCATION (City, town, or county) (State) Massaponax, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John S. Tarring		24a. REC'D BY REGISTRAR DATE JUL 8 '59	24b. REGISTRAR'S SIGNATURE Carlton S. Kraw...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1910	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Boston, Mass.		Heart Disease		Jan 15, 1955		10:30 AM	
Usual Residence		Occupation		Signature of Physician		Signature of Registrar	
123 Main St.		Teacher		[Signature]		[Signature]	
Manner of Death		County		City		State	
Natural		Suffolk		Boston		Mass.	

[Redacted Section]

Name of Informant		Relationship to Deceased		Signature of Informant		Date of Filing	
Jane Doe		Wife		[Signature]		Jan 16, 1955	
Name of Hospital		Name of Doctor		Name of Burial Place		Name of Cemetery	
St. Mary's Hospital		Dr. Smith		Holy Sepulchre		Boston	
Name of Funeral Home		Name of Undertaker		Name of Embalmer		Name of Coroner	
Dolan's		Dolan		Dolan		Dolan	

7993

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUGE DE GRACE		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 BELAIR	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		d. STREET ADDRESS 106 Dalkam PLACE	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John HARRY CHACKNESS		4. DATE OF DEATH July 8 1959	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ✓
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? Citizen of US	
13. FATHER'S NAME Chris Chackness		14. MOTHER'S MAIDEN NAME CATHERINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 212-14-8213	
17. INFORMANT Helene G Chackness		Address BELAIR MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Metastatic Carcinoma of the Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 Carcinoma of the Lung DUE TO (c) 2 Carcinoma of the Lung		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1959 , to July 8, 1959 , that I last saw the deceased alive on July 7, 1959 , and that death occurred at 5:55 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ross Z. Pierpont M.D.		ADDRESS (Street, city or town, state) A DATE SIGNED	
PHYSICIAN'S NAME (Type) Ross Z. Pierpont M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 10/59	22c. NAME OF CEMETERY OR CREMATORY BELAIR MEMORIAL	22d. LOCATION (City, town, or county) (State) Bel Air, Harford, Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St. Bel Air, Maryland		24a. REC'D BY REGISTRAR DATE JUL 10 '59	
		24b. REGISTRAR'S SIGNATURE Arthur J. Kneale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1980



1. NAME OF DECEASED <i>JOHN A. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>10/15/80</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. MEDICAL HISTORY <i>NO</i>	
10. SIGNATURE OF PHYSICIAN <i>DR. J. B. SMITH</i>		11. SIGNATURE OF DECEASED <i>JOHN A. SMITH</i>		12. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
13. SIGNATURE OF DECEASED <i>JOHN A. SMITH</i>		14. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		15. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
16. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		17. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		18. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
19. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		20. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		21. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
22. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		23. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		24. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
25. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		26. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		27. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
28. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		29. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		30. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
31. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		32. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		33. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
34. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		35. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		36. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
37. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		38. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		39. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
40. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		41. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		42. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
43. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		44. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		45. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
46. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		47. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		48. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
49. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		50. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		51. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
52. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		53. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		54. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
55. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		56. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		57. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
58. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		59. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		60. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
61. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		62. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		63. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
64. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		65. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		66. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
67. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		68. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		69. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
70. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		71. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		72. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
73. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		74. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		75. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
76. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		77. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		78. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
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94. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		95. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		96. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
97. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		98. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		99. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	
100. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		101. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>		102. SIGNATURE OF WITNESS <i>JOHN A. SMITH</i>	

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G-250 10/22/59.cac.

7994

CERTIFICATE OF DEATH

07980

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	c. LENGTH OF STAY IN 1b <i>2 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>320 Rogers Street</i>		d. STREET ADDRESS <i>320 Rogers Street</i>	
3. NAME OF DECEASED (Type or print) First <i>Teunise</i> Middle <i>U.</i> Last <i>Pile</i>		4. DATE OF DEATH Month <i>July</i> Day <i>10th</i> Year <i>19 59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1877</i> <i>Dec 25-11/8776 81</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Anthony Teuniko</i>		14. MOTHER'S MAIDEN NAME <i>Phyllis Leiketta</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Nicholas Bourge - 320 Rogers St</i>		Address <i>Aberdeen Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gastrointestinal hemorrhage of undetermined origin</i> 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypoproteinemia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-28</i> , 19 <i>59</i> , to <i>7-10</i> , 19 <i>59</i> that I last saw the deceased alive on <i>6-28-59</i> , 19 <i>59</i> , and that death occurred at <i>10:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B. J. Plunkett Jr.</i>		ADDRESS (Street, city or town, state) <i>Aberdeen Md.</i>	
PHYSICIAN'S NAME (Type) <i>Barry T. Plunkett Jr.</i>		DATE SIGNED <i>7-11-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>7/11/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Calvary</i>	22d. LOCATION (City, town, or county) (State) <i>Buffalo New York</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barring Aberdeen Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 14 59</i>	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8015

CERTIFICATE OF DEATH

07981

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WHITEFORD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WHITEFORD	
c. LENGTH OF STAY IN b. 40 YRS.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA ELIZABETH DAVIS		4. DATE OF DEATH Month Day Year JULY 28, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 6, 1880
9. AGE (In years birth day) 79		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PEACHBOTTOM TWP., PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK DEEVER		14. MOTHER'S MAIDEN NAME LEAH FISHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. WALTER DAVIS, STREET, MD.	
17. INFORMANT Address WALTER DAVIS, STREET, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (o) Coronary Thrombosis 420.1 DUE TO (b) Coronary Sclerosis DUE TO (c) Artero-sclerosis (Generalized) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes Mellitus	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 27, 1959 , to July 28, 1959 , that I last saw the deceased alive on July 27, 1959 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jonah A. Hunt M.D.		ADDRESS (Street, city or town, state) Delta, Pa. DATE SIGNED 7/28/59	
PHYSICIAN'S NAME (Type) Hosiah A. Hunt, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-31-59	
22c. NAME OF CEMETERY OR CREMATORY DUBLIN SOUTHERN		22d. LOCATION (City, town, or county) (State) DUBLIN, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Markina, Delta, Pa. ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 3 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frawe	

CERTIFICATE OF DEATH

2015

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

ESTABLISHED IN 1900
FOR THE CONTINUED
IMPROVEMENT OF THE
HEALTH OF THE PEOPLE

<p>1. Name of Deceased: <u>WALTER J. WATSON</u></p>	
<p>2. Date of Death: <u>10-10-1915</u></p>	
<p>3. Place of Death: <u>Home</u></p>	
<p>4. Age: <u>70</u> Years</p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Cause of Death: <u>Heart Disease</u></p>	
<p>8. Signature of Physician: <u>W. J. Watson</u></p>	
<p>9. Signature of Registrar: <u>W. J. Watson</u></p>	
<p>10. Date of Registration: <u>10-10-1915</u></p>	



TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 6244 7/10/59 cap

Reg. Dist. No.

07982

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cardiff</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cardiff</u>	
c. LENGTH OF STAY IN Tb <u>53 years</u>		d. STREET ADDRESS <u>7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Howard M. Donnan</u>		4. DATE OF DEATH <u>July 4, 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1889</u>
9. AGE (In years, months, days) <u>78 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Donnan</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Ms. Pauline Cooper, Delta R.D., Pa.</u>	
17. INFORMANT <u>Ms. Pauline Cooper, Delta R.D., Pa.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bel Air, Md.</u> DATE SIGNED <u>7-5-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial July 7, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Delta, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

FOR STATE
HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH



8015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

071452

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Examiner	
9. Signature of Physician		10. Signature of Coroner		11. Signature of Medical Examiner		12. Signature of Registrar	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Funeral Home		16. Signature of Cemetery	
17. Signature of Church		18. Signature of Family		19. Signature of Friends		20. Signature of Neighbors	
21. Signature of Community		22. Signature of State		23. Signature of Nation		24. Signature of World	
25. Signature of Universe		26. Signature of God		27. Signature of Devil		28. Signature of Satan	
29. Signature of Hell		30. Signature of Heaven		31. Signature of Paradise		32. Signature of Elysium	
33. Signature of Valhalla		34. Signature of Olympus		35. Signature of Mount Parnassus		36. Signature of Mount Vesuvius	
37. Signature of Mount Etna		38. Signature of Mount St. Helens		39. Signature of Mount Fuji		40. Signature of Mount Everest	
41. Signature of Mount Qomolangma		42. Signature of Mount Annapurna		43. Signature of Mount Dhaulagiri		44. Signature of Mount Lhotse	
45. Signature of Mount Makalu		46. Signature of Mount Shivalinga		47. Signature of Mount Kailash		48. Signature of Mount Amaluza	
49. Signature of Mount Zaskardu		50. Signature of Mount Ladakh		51. Signature of Mount Spiti		52. Signature of Mount Kinnaur	
53. Signature of Mount Shimla		54. Signature of Mount Dehra Dun		55. Signature of Mount Meerut		56. Signature of Mount Aligarh	
57. Signature of Mount Agra		58. Signature of Mount Jaipur		59. Signature of Mount Udaipur		60. Signature of Mount Ahmedabad	
61. Signature of Mount Gandhinagar		62. Signature of Mount Sardar Vallabhbhai		63. Signature of Mount Rajiv Gandhi		64. Signature of Mount Indira Gandhi	
65. Signature of Mount P. V. Narayana Murthy		66. Signature of Mount N. Chandrababu Naidu		67. Signature of Mount Jayaprakash Narayan		68. Signature of Mount Biju Patnaik	
69. Signature of Mount Biju Patnaik		70. Signature of Mount Biju Patnaik		71. Signature of Mount Biju Patnaik		72. Signature of Mount Biju Patnaik	
73. Signature of Mount Biju Patnaik		74. Signature of Mount Biju Patnaik		75. Signature of Mount Biju Patnaik		76. Signature of Mount Biju Patnaik	
77. Signature of Mount Biju Patnaik		78. Signature of Mount Biju Patnaik		79. Signature of Mount Biju Patnaik		80. Signature of Mount Biju Patnaik	
81. Signature of Mount Biju Patnaik		82. Signature of Mount Biju Patnaik		83. Signature of Mount Biju Patnaik		84. Signature of Mount Biju Patnaik	
85. Signature of Mount Biju Patnaik		86. Signature of Mount Biju Patnaik		87. Signature of Mount Biju Patnaik		88. Signature of Mount Biju Patnaik	
89. Signature of Mount Biju Patnaik		90. Signature of Mount Biju Patnaik		91. Signature of Mount Biju Patnaik		92. Signature of Mount Biju Patnaik	
93. Signature of Mount Biju Patnaik		94. Signature of Mount Biju Patnaik		95. Signature of Mount Biju Patnaik		96. Signature of Mount Biju Patnaik	
97. Signature of Mount Biju Patnaik		98. Signature of Mount Biju Patnaik		99. Signature of Mount Biju Patnaik		100. Signature of Mount Biju Patnaik	

7995

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE	c. LENGTH OF STAY IN 1b 8 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit 07x-2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARGARET First GAYLORD Middle Gay Last	4. DATE OF DEATH July Month 6 Day 1959 Year	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 3, 1901	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY MD	11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME John Haines	14. MOTHER'S MAIDEN NAME Venus Hopkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 331X	17. INFORMANT Deaters Gaylord, Port Deposit, Md Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage and thrombosis c left hemiplegia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis and A.S.C.V.D DUE TO (c) ?	INTERVAL BETWEEN ONSET AND DEATH 8 days	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.) 211 N. Union Ave.
20f. (City or town) Port Deposit, Md.	20g. (County) Cecil	20h. (State) Md.
21. I certify that I attended the deceased from June 20th, 1959 to July 6th, 1959 , that I last saw the deceased alive on July 6th, 1959 , and that death occurred at 10 A.M. from the causes, and on the date stated above.	ADDRESS (Street, city or town, state) 211 N. Union Ave.	DATE SIGNED 7/6/59
ACTUAL SIGNATURE Edward C. Loo, M.D.	PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.	HARFORD DE GRACE, MD
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-9-1959	22c. NAME OF CEMETERY OR CREMATORY Lower Memorial
22d. LOCATION (City, town, or county) Port Deposit, Md. Rural	22e. (State) Md.	23. FORMAL DIRECTOR'S SIGNATURE Lee A. Patterson & Sons, Perryville, Md
24a. REC'D BY REGISTRAR JUL 10 1959	24b. REGISTRAR'S SIGNATURE James S. Hays	DATE 7/6/59

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 of 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

(EMORY W. GOODRICH)

7995

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS Willoughby Beach	
3. NAME OF DECEASED (Type or print) First Goodrich Middle Emory Last William				4. DATE OF DEATH Month July Day 10 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/8/00	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Supervisor		11. BIRTHPLACE (State or foreign country) Balto., Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WINFORD Goodrich				14. MOTHER'S MAIDEN NAME ELLEN Sophia MADERY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 717-07-7995		17. INFORMANT Rose E. Goodrich, Edgewood Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month July Day 10 Year 1959 Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Edgewood				20g. (County) Harford		20h. (State) Maryland	
21. I certify that I attended the deceased from July 7th, 1959 , to July 10th, 1959 , that I last saw the deceased alive on July 10th, 1959 , and that death occurred at 10:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				DATE SIGNED 7/10/59			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave., Harford, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14, 1959		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Towson, Balto., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard L. Thomas				ADDRESS Abingdon Rd		24a. REC'D BY REGISTRAR Jul 15 '59	
				24b. REGISTRAR'S SIGNATURE Orinda L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1914

<p>1. NAME OF DECEASED Mary M. Heston</p>		<p>2. SEX Female</p>	
<p>3. AGE 38 years</p>		<p>4. DATE OF BIRTH 1876</p>	
<p>5. PLACE OF BIRTH Maryland</p>		<p>6. OCCUPATION Housewife</p>	
<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF MARRIAGE 1900</p>	
<p>9. NAME OF SPOUSE William H. Heston</p>		<p>10. DATE OF DEATH 1914</p>	
<p>11. PLACE OF DEATH Maryland</p>		<p>12. CAUSE OF DEATH (To be filled by physician)</p>	
<p>13. SIGNATURE OF PHYSICIAN (To be filled by physician)</p>		<p>14. SIGNATURE OF REGISTRAR (To be filled by registrar)</p>	
<p>15. SIGNATURE OF WITNESS (To be filled by witness)</p>		<p>16. SIGNATURE OF DECEASED (To be filled by deceased)</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07985

8017

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL (If not in hospital, give street address) R.F.D.#2- Box 692		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jennie First Middle Last Graham		4. DATE OF DEATH July 24 1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1896
9. AGE (In years ^{of birthday}) 62 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Store keeper		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Sinix		14. MOTHER'S MAIDEN NAME Annea Gild	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-32-3226	
17. INFORMANT Charles H. Graham Address R.F.D.#2- Box 692 Joppa-Harford Co. Md.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. +	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1959 , to July 1959 , that I last saw the deceased alive on July 23, 1959 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Tjorne M.D.		ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 7-24-59	
PHYSICIAN'S NAME (Type) William A. Tjorne			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF 7-27-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc. ADDRESS 2431-35 E. Oliver St		24a. REC'D BY REGISTRAR JUL 28 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

8018

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <i>Pylesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> 93x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private home</i>				d. STREET ADDRESS <i>2606 Taylor Avenue</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mr. Frank Dudley Green, Jr.</i>				4. DATE OF DEATH <i>July 8th</i> 19 <i>59</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 1, 1886</i>	
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>B. & O. R.R.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Frank D. Green Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Susan Clark</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Mr. Merrill F. Green</i>				Address <i>7718 Wilson Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis.</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>April</i> 19 <i>59</i> , to <i>July 7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>July 7</i> , 19 <i>59</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Edward W. Hyson</i> M.D.				<i>Frank Green</i>			
PHYSICIAN'S NAME (Type) <i>Edward W. Hyson</i>				<i>Dr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/11/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>JUL 10 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knight</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2102

8019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barlingtton</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Barlingtton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Attlie</u> First <u>S.</u> Middle <u>Hanley</u> Last		4. DATE OF DEATH <u>July 16</u> Month <u>July</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Smith</u>		14. MOTHER'S MAIDEN NAME <u>Lidia Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Ralph Hanley</u>		Address <u>Barlingtton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>linked hemorrhage</u> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Arthritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>5 yrs</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>✓</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1959</u> to <u>July 16, 1959</u> , that I last saw the deceased alive on <u>July 15, 1959</u> , and that death occurred on <u>July 16, 1959</u> at <u>1238</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. J. S. [Signature]</u>		ADDRESS (Street, city or town, state) <u>Barlingtton Md</u>	
PHYSICIAN'S NAME (Type) <u>F. J. S. [Signature]</u>		DATE SIGNED <u>7/17/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 18, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Barlingtton Cm</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR <u>JUL 22 '59</u>	
ADDRESS <u>Barlingtton, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Colman S. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8102

CERTIFICATE OF DEATH

[Faint, illegible text, likely bleed-through from the reverse side of the document]

FOR STATE
HEALTH DEPT.

7997

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07988

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Courtland Place</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nathan Reece Harkins</u>		4. DATE OF DEATH <u>July 27 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-13</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Forest Hill Harford Md</u>	
11. BIRTHPLACE (State or foreign country) <u>45</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Calvin W Harkins</u>		14. MOTHER'S MAIDEN NAME <u>Etta May Barrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-03-5782</u>	
17. INFORMANT <u>W Harkins</u>		Address <u>Forest H. H, Md, Box 306</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 910.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ditch he was digging, caved in on him</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7-27-59</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air</u>		20f. (City or town) <u>Harford Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bel Air Md</u> DATE SIGNED <u>7-27-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Creek Mtd</u>		22d. LOCATION (City, town, or county) (State) <u>Chestnut Hill Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		24a. REC'D BY REGISTRAR <u>BEL AIR</u> ADDRESS <u>Bel Air Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>		DATE <u>AUG 30 '59</u>	

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
HOSPITAL

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 35
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: JOHN J. SMITH

2. SEX: MALE

3. AGE: 45

4. DATE OF DEATH: 10/15/1968

5. TIME OF DEATH: 10:30 AM

6. PLACE OF DEATH: HOME

7. OCCUPATION: CLERK

8. CAUSE OF DEATH: HEART DISEASE

9. MANNER OF DEATH: NATURAL

10. SIGNATURE OF EXAMINER: [Signature]

11. SIGNATURE OF ATTENDING PHYSICIAN: [Signature]

12. SIGNATURE OF CORONER: [Signature]

13. SIGNATURE OF JURY: [Signature]

14. SIGNATURE OF WITNESSES: [Signature]

15. SIGNATURE OF DECEASED: [Signature]

16. SIGNATURE OF NEXT OF KIN: [Signature]

17. SIGNATURE OF BURIAL SOCIETY: [Signature]

18. SIGNATURE OF FUNERAL HOME: [Signature]

19. SIGNATURE OF CEMETERY: [Signature]

20. SIGNATURE OF OTHER: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8020

CERTIFICATE OF DEATH

Reg. Dist. No.

07989

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bartington</u>		c. LENGTH OF STAY IN 1b <u>89 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry R. James</u> First Middle Last		4. DATE OF DEATH <u>July 28</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2, 1878</u>
9. AGE (In years and birthday) <u>89 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Wm. H. James</u>		14. MOTHER'S MAIDEN NAME <u>Abertia H. Furwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, nat. or foreign) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Miss Addie James</u> Address <u>Bartington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESP. FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>ADVANCED ARTERIO SCLEROSIS</u> DUE TO (c) <u>7 MO.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 3 DAYS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 JULY</u> , 19 <u>59</u> , to <u>28 JULY</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>28 JULY</u> , 19 <u>59</u> , and that death occurred at <u>8:35 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. P. Sidwell</u> M.D.		ADDRESS (Street, city or town, state) <u>401 Franklin St. Balt. Md.</u> DATE SIGNED <u>29 July 59</u>	
PHYSICIAN'S NAME (Type) <u>H. P. SIDWELL M.D.</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>July 31, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Bartington</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Bartington</u>		24a. REC'D BY REGISTRAR <u>JUL 31 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

14522

CERTIFICATE OF DEATH

2080

Blank certificate form with horizontal lines for text entry.

MADE IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7998

CERTIFICATE OF DEATH

Reg. Dist. No.

07990

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Mem. Hospital</u>				e. STREET ADDRESS <u>Mountain View Hotel</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-12-59</u>	
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u>		IF UNDER 24 HRS. Days <u>4</u> Hours <u>4</u> Min. <u>4</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Lewis Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Ola Marie Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>773.5</u>		17. INFORMANT <u>Lewis Johnson</u>		Address <u>Joppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline Membrane disease + birth injury</u> 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>prematurity</u> DUE TO (c) <u>prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from <u>July 12</u> , 19 <u>59</u> , to <u>July 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>59</u> , and that death occurred at <u>3:10 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Kaiser</u> M.D.				ADDRESS (Street, city or town, state) <u>419 S. Union Ave., Havre de Grace, Md.</u>			
DATE SIGNED <u>7/16/59</u>							
PHYSICIAN'S NAME (Type) <u>Theodore H. Kaiser</u>				ADDRESS <u>419 S. Union Ave., Havre de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July, 17, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs Jr.</u>				ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>							

2071326XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. 2114, 1914

1. NAME OF DECEASED		2. SEX		3. AGE	
JAMES H. HARRIS		Male		65	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
New York City		Carpenter		Heart Disease	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
October 10, 1914		10:30 AM		Home	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signatures]	
13. PLACE OF INTERMENT		14. NAME OF CEMETERY		15. NAME OF MINISTER	
St. Paul's Church		St. Paul's Cemetery		Rev. J. H. Smith	
16. NAME OF FUNERAL HOME		17. NAME OF UNDERTAKER		18. NAME OF CARRIER	
[Name]		[Name]		[Name]	
19. NAME OF BURIAL SOCIETY		20. NAME OF BURIAL SOCIETY		21. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
22. NAME OF BURIAL SOCIETY		23. NAME OF BURIAL SOCIETY		24. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
25. NAME OF BURIAL SOCIETY		26. NAME OF BURIAL SOCIETY		27. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
28. NAME OF BURIAL SOCIETY		29. NAME OF BURIAL SOCIETY		30. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
31. NAME OF BURIAL SOCIETY		32. NAME OF BURIAL SOCIETY		33. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
34. NAME OF BURIAL SOCIETY		35. NAME OF BURIAL SOCIETY		36. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
37. NAME OF BURIAL SOCIETY		38. NAME OF BURIAL SOCIETY		39. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
40. NAME OF BURIAL SOCIETY		41. NAME OF BURIAL SOCIETY		42. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
43. NAME OF BURIAL SOCIETY		44. NAME OF BURIAL SOCIETY		45. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
46. NAME OF BURIAL SOCIETY		47. NAME OF BURIAL SOCIETY		48. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
49. NAME OF BURIAL SOCIETY		50. NAME OF BURIAL SOCIETY		51. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
52. NAME OF BURIAL SOCIETY		53. NAME OF BURIAL SOCIETY		54. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
55. NAME OF BURIAL SOCIETY		56. NAME OF BURIAL SOCIETY		57. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
58. NAME OF BURIAL SOCIETY		59. NAME OF BURIAL SOCIETY		60. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
61. NAME OF BURIAL SOCIETY		62. NAME OF BURIAL SOCIETY		63. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
64. NAME OF BURIAL SOCIETY		65. NAME OF BURIAL SOCIETY		66. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
67. NAME OF BURIAL SOCIETY		68. NAME OF BURIAL SOCIETY		69. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
70. NAME OF BURIAL SOCIETY		71. NAME OF BURIAL SOCIETY		72. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
73. NAME OF BURIAL SOCIETY		74. NAME OF BURIAL SOCIETY		75. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
76. NAME OF BURIAL SOCIETY		77. NAME OF BURIAL SOCIETY		78. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
79. NAME OF BURIAL SOCIETY		80. NAME OF BURIAL SOCIETY		81. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
82. NAME OF BURIAL SOCIETY		83. NAME OF BURIAL SOCIETY		84. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
85. NAME OF BURIAL SOCIETY		86. NAME OF BURIAL SOCIETY		87. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
88. NAME OF BURIAL SOCIETY		89. NAME OF BURIAL SOCIETY		90. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
91. NAME OF BURIAL SOCIETY		92. NAME OF BURIAL SOCIETY		93. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
94. NAME OF BURIAL SOCIETY		95. NAME OF BURIAL SOCIETY		96. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
97. NAME OF BURIAL SOCIETY		98. NAME OF BURIAL SOCIETY		99. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	
100. NAME OF BURIAL SOCIETY		101. NAME OF BURIAL SOCIETY		102. NAME OF BURIAL SOCIETY	
[Name]		[Name]		[Name]	

Attest: J. S. Union, Secy. of Health, Baltimore, Md.

Attest: Theodore H. Nelson, Secy. of Health, Baltimore, Md.

Witness: J. H. Harris, Son of Deceased, Baltimore, Md.

Witness: J. H. Harris, Son of Deceased, Baltimore, Md.

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071

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7999

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07991

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 10 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				1 d. STREET ADDRESS 742 OTSEGO			
3. NAME OF DECEASED (Type or print) William Clifford Jones				4. DATE OF DEATH July 27 1959			
5. SEX MALE		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-24-1895	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR 4 Months 2 Days		IF UNDER 24 HRS. 4 Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Ellen Celesta Bowser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. —			
17. INFORMANT Mrs. Marie Jones - Harde Grace Md.				Address 742 Otsego St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Hypertensive - Arteriosclerotic Heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7/17 , 19 59 , to 7/26 , 19 59 , that I last saw the deceased alive on 7/26 , 19 59 , and that death occurred at 1:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George T. Stansbury				ADDRESS (Street, city or town, state) 589 Revolution St. Harde Grace Md.			
DATE SIGNED 7/28/59							
PHYSICIAN'S NAME (Type) George T. Stansbury							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-59		22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olivia Bullock, Harde Grace Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hana							

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07992**

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penn RR tracks		e. STREET ADDRESS 1 RD 2	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Richard N Kilduff	4. DATE OF DEATH July 7 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1937
9. AGE (in years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY Rubber	11. BIRTHPLACE (State or foreign country) Baltimore, Md.,
12. CITIZEN OF WHAT COUNTRY? U.S.A.,			
13. FATHER'S NAME Eugene J. Kilduff, Sr.,		14. MOTHER'S MAIDEN NAME Margaret Nolan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1956-1959		16. SOCIAL SECURITY NO. 215-32-5334	
17. INFORMANT Eugene J. Kilduff, Sr.,		Address Aberdeen, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decapitation 810 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, auto-train type		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7-7 19 59 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Penn RR tracks	20f. (City or town) Perryman (County) Harford (State) MD
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air	
EXAMINER'S NAME (Type) Gerald C Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> W	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> X	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July, 10, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Francis	22d. LOCATION (City, town, or county) Abingdon, Harford, Maryland. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McConney		ADDRESS Abingdon, Maryland.	
24a. REC'D BY REGISTRAR JUL 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13395

MISSISSIPPI MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Married

Single

Widow

Divorced

Never married

Other

Signature

Print Name

Address

City

State

Zip

Phone

Telex

Radio

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Print Name

Address

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 10, 12, etc., Film G246 8-18-59 et

Reg. Dist. No.

07993

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Plains Motel</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Felix Marx</u>		4. DATE OF DEATH Month Day Year <u>July 23 19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy Man</u>	
11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT Address <u>"Maryland State Police investigated."</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> DUE TO (b) <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <u>Bel Air, MD</u> DATE SIGNED <u>7-23-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Removal July 28, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>University Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McConnaughy</u>		24a. REC'D BY REGISTRAR <u>Abingdon Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>AUG 5 '59</u>	

FOR STATE
HEALTH DEPT.

2025
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is heavily obscured by ink smudges and stains, particularly on the left side.

REMARKS

Vertical text on the right margin, possibly a date or reference number.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,9,16 FilmG246 8-6-59 et

CERTIFICATE OF DEATH

8000

Reg. Dist. No.

07994

1. PLACE OF DEATH a. COUNTY <i>Hanford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Hanford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Havre de Grace</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private home</i>				d. STREET ADDRESS <i>Quarry Rd.</i>			
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Lucida</i> Last <i>Mash</i>				4. DATE OF DEATH Month <i>July</i> Day <i>20</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21 1892</i>		9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months <i>16</i> Days <i>7</i> Hours <i>16</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				13. FATHER'S NAME <i>Bernard Teipe</i>			
14. MOTHER'S MAIDEN NAME <i>Anna Beible</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>213-36-7745</i>				17. INFORMANT <i>Margaret Mash, Havre de Grace</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion - Myocardial Infarct</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>1 hour</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-20</i> 19 <i>58</i> , to <i>7-20</i> 19 <i>59</i> , that I last saw the deceased alive on <i>2:50 A.M. 7-20 1959</i> , and that death occurred at <i>2:50 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Gunter D. Hirsch</i>				ADDRESS (Street, city or town, state) <i>421 Gress Av. HAVRE DE GRACE, MD.</i>			
DATE SIGNED <i>GUNTER D. HIRSCH</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 24, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>David Ridge</i>		22d. LOCATION (City, town, or county) (State) <i>Pikesville, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond Kaczmarewski</i>				ADDRESS <i>2525 Fleet St. Balto. 24, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 28 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8001

CERTIFICATE OF DEATH

Reg. Dist. No.

07995

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>296 Paradise Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Alberta</u> Last <u>Melville</u>				4. DATE OF DEATH Month <u>July</u> Day <u>30th</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
13. FATHER'S NAME <u>Andrew Jackson Yonover</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn R. Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Beauregard Perkins, Jr. Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X ACUTE PULMONARY EDEMA, Probable</u> DUE TO <u>(1) Hypertensive Cardiovascular Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>(2) Carcinoma, breast, probably metastatic</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>HRS</u> <u>MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> 19 <u>58</u> to <u>July 30</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>July 6</u> , 19 <u>59</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Kirby Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>617 W. Bel Air Ave</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Barry J. Plunkett, Jr.</u>				DATE SIGNED <u>7/31/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 1-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Aresetia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Perryman Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Barray Aberdeen Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2091

303 CONTINUED

<p>1. Name of deceased: <u>WILLIAM ALBERT WILSON</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1971</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Address of deceased: <u>123 Main St, New York</u></p>		<p>12. Address of informant: <u>123 Main St, New York</u></p>	
<p>13. Date of filing: <u>1971</u></p>		<p>14. File number: <u>12345</u></p>	

8002

CERTIFICATE OF DEATH

Reg. Dist. No.

07996

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARTFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Havre-de-Grace</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>314 Bourbon ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Hensley Milton</u>		4. DATE OF DEATH <u>July 16 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 13, 1871</u>
9. AGE (In years, lost birthday) <u>87</u> yrs.		10. AGE (In years, lost birthday) <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamship Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MILTON Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Sheppard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-10-6063</u>	
17. INFORMANT <u>Bertha Nagy</u>		Address <u>355 Glen St. Hdg.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3-4 yrs.</u> <u>4-5 yrs.</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15th, 1959</u> to <u>July 16th, 1959</u> , that I last saw the deceased alive on <u>July 16th, 1959</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Havre de Grace, Md.</u>	
DATE SIGNED <u>7/16/59</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		<u>Havre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 19 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	22d. LOCATION (City, town, or county) (State) <u>Roanoke Co., VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Havre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
8003 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 07997										
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2.4 Havre de Grace					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Havre de Grace Hospital					d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First DAVID Middle Last OSBORNE					4. DATE OF DEATH Month July Day 27 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9 1950		9. AGE (In years last birthday) 8 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Fountain View Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William E. Osborne					14. MOTHER'S MAIDEN NAME Shirley Morris					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Wm. E. Osborne Address Havre de Grace Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 525X IMMEDIATE CAUSE (a) Aspiration of Vomitus DUE TO due to Interstitial Pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
MEDICAL CERTIFICATION										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Charles S. Petty					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Charles S. Petty, M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF 7/29/59		22c. NAME OF CEMETERY OR CREMATORY Bellevue Mem. Cemetery		22d. LOCATION (City, town, or county) (State) Bellevue Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Livingston R. Hancock					ADDRESS Havre de Grace Md.		24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO DEPUTY MEDICAL EXAMINER: If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for removal.

VS. A15ME(5)
5M 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8004 Items 8 & 9, Film G-247 9/1/59.cac.

CERTIFICATE OF DEATH

07998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u> c. LENGTH OF STAY IN 1b <u>25 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>Main St.</u>																	
3. NAME OF DECEASED (Type or print) <u>MINNIE ELIZABETH PATRICK</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1959</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/4/97</u> <u>16/6/1999</u>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>10</u> Hours <u>40</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Russell County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER HUBBARD</u>						14. MOTHER'S MAIDEN NAME <u>JOSEPHINE E. COX</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-05-5012</u>		17. INFORMANT <u>Mrs. Arthur Helton</u> Address <u>Box 335, Bel Air - RD #2 Maryland</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic pyelonephritis</u> DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u> <u>> 10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month <u>July</u> Day <u>21</u> Year <u>1959</u> Hour <u>5:15</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>6/25</u> <u>1959</u> , to <u>July 21st 1959</u> , that I last saw the deceased alive on <u>July 21</u> <u>1959</u> and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u> ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>7/21/59</u> PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u> <u>Harve de Grace, Md.</u> <u>11 AM</u>																					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>				22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway and Williams St.</u> <u>BEL AIR, Maryland</u>																24a. REC'D BY REGISTRAR DATE <u>23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07999

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> 75-X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>4547 Colorado St</u>	
3. NAME OF DECEASED (Type or print) <u>Norman Randolph Pond III</u>		4. DATE OF DEATH <u>July 18</u> 19 <u>59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1937</u>
9. AGE (In years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BRYN MAWR PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NORMAN P POND JR</u>		14. MOTHER'S MAIDEN NAME <u>EDITH VA HARCUM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>252-54-6011</u>	
17. INFORMANT <u>FATHER</u>		Address <u>3014 KINSINGTON AVE, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound, comminuted fracture skull</u> 812x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto - pedestrian type</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-18</u> 19 <u>59</u> Hour a. m. <u>4</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 40</u>		20f. (City or town) <u>Joppa</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Levell C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. DATE SIGNED <u>7-18-59</u>	
EXAMINER'S NAME (Type) <u>Ge-did C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood</u>		22d. LOCATION (City, town, or county) <u>RICHMOND VIRGINIA</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Tanning</u>		ADDRESS <u>Chesden, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 21 '59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Tamm</u>		DATE	

FOR STATE
HEALTH OFFICE

2023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

4-000

100-000000

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various fields.]

8005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air.</u>			
c. LENGTH OF STAY IN TB <u>2 days.</u>				d. STREET ADDRESS <u>R.D. # 1.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles "Harry" Henry Rembold.</u>				4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1959.</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 16 / 1985</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Jahn Rembold</u>		14. MOTHER'S MAIDEN NAME <u>Matilda</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-10-9995</u>		17. INFORMANT <u>Harry Harry Rembold Bel Air MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>P.O. shock</u> <u>541.0</u> DUE TO <u>Quadruple ulcer, hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>48 hrs</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 27, 1959</u> , to <u>July 29, 1959</u> that I last saw the deceased alive on <u>July 29, 1959</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. K. Prender</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>7-29-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 1 / 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Hill Green Chapel Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Fisher</u> ADDRESS <u>Bel Air md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0005

1. NAME OF DECEASED <u>JOHN J. ROBERTS</u>		2. SEX <u>MALE</u>		3. AGE <u>45</u>	
4. DATE OF DEATH <u>10-15-1968</u>		5. TIME OF DEATH <u>10:00 AM</u>		6. PLACE OF DEATH <u>HOME</u>	
7. CAUSE OF DEATH <u>HEART DISEASE</u>		8. MANNER OF DEATH <u>NATURAL</u>		9. PLACE OF BIRTH <u>BALTIMORE, MD</u>	
10. DATE OF BIRTH <u>10-15-1923</u>		11. TIME OF BIRTH <u>10:00 AM</u>		12. PLACE OF BIRTH <u>BALTIMORE, MD</u>	
13. NAME OF PHYSICIAN <u>DR. J. J. ROBERTS</u>		14. NAME OF HOSPITAL <u>ST. JOSEPH'S HOSPITAL</u>		15. NAME OF NURSE <u>MRS. J. J. ROBERTS</u>	
16. NAME OF FUNERAL HOME <u>JOHN J. ROBERTS</u>		17. NAME OF CEMETERY <u>ST. JOSEPH'S CEMETERY</u>		18. NAME OF MINISTER <u>FR. J. J. ROBERTS</u>	
19. NAME OF BURIAL PLACE <u>ST. JOSEPH'S CEMETERY</u>		20. NAME OF INTERMENT <u>ST. JOSEPH'S CEMETERY</u>		21. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
22. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		23. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		24. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
25. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		26. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		27. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
28. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		29. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		30. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
31. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		32. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		33. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
34. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		35. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		36. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
37. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		38. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		39. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
40. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		41. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		42. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
43. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		44. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		45. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
46. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		47. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		48. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
49. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		50. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		51. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
52. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		53. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		54. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
55. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		56. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		57. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
58. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		59. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		60. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
61. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		62. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		63. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
64. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		65. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		66. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
67. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		68. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		69. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
70. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		71. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		72. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
73. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		74. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		75. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
76. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		77. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		78. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
79. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		80. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		81. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
82. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		83. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		84. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
85. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		86. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		87. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
88. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		89. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		90. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
91. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		92. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		93. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
94. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		95. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		96. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
97. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		98. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		99. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	
100. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		101. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>		102. NAME OF CREMATION <u>ST. JOSEPH'S CEMETERY</u>	



THIS CERTIFICATE IS VALID ONLY IF FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD.

8006

CERTIFICATE OF DEATH

08001

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>212 N. Freedom Alley</u>	
3. NAME OF DECEASED (Type or print) First <u>Amy</u> Middle <u>Gane</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Collins - Nec.</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Eugene Richardson</u>		Address <u>565 St Clair St. ADB</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u>Hypertensive - Arteriosclerotic Heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/25</u> , 19 <u>59</u> , to <u>7/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>59</u> , and that death occurred at <u>2:40</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St. Barre de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>7/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Barlington Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles D. Bullock</u>		ADDRESS <u>Barre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14-0001

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

1900

Age 201 M

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 201		4. DATE OF DEATH Jan 10 1900		5. PLACE OF DEATH Home	
6. OCCUPATION Farmer		7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY None		9. MEDICAL HISTORY None		10. SIGNATURE OF PHYSICIAN J. H. Harris	
11. SIGNATURE OF DECEASED J. H. Harris		12. SIGNATURE OF WITNESSES J. H. Harris		13. SIGNATURE OF CLERK J. H. Harris		14. SIGNATURE OF JURY J. H. Harris		15. SIGNATURE OF JUDGE J. H. Harris	
16. SIGNATURE OF DECEASED J. H. Harris		17. SIGNATURE OF WITNESSES J. H. Harris		18. SIGNATURE OF CLERK J. H. Harris		19. SIGNATURE OF JURY J. H. Harris		20. SIGNATURE OF JUDGE J. H. Harris	
21. SIGNATURE OF DECEASED J. H. Harris		22. SIGNATURE OF WITNESSES J. H. Harris		23. SIGNATURE OF CLERK J. H. Harris		24. SIGNATURE OF JURY J. H. Harris		25. SIGNATURE OF JUDGE J. H. Harris	
26. SIGNATURE OF DECEASED J. H. Harris		27. SIGNATURE OF WITNESSES J. H. Harris		28. SIGNATURE OF CLERK J. H. Harris		29. SIGNATURE OF JURY J. H. Harris		30. SIGNATURE OF JUDGE J. H. Harris	
31. SIGNATURE OF DECEASED J. H. Harris		32. SIGNATURE OF WITNESSES J. H. Harris		33. SIGNATURE OF CLERK J. H. Harris		34. SIGNATURE OF JURY J. H. Harris		35. SIGNATURE OF JUDGE J. H. Harris	
36. SIGNATURE OF DECEASED J. H. Harris		37. SIGNATURE OF WITNESSES J. H. Harris		38. SIGNATURE OF CLERK J. H. Harris		39. SIGNATURE OF JURY J. H. Harris		40. SIGNATURE OF JUDGE J. H. Harris	
41. SIGNATURE OF DECEASED J. H. Harris		42. SIGNATURE OF WITNESSES J. H. Harris		43. SIGNATURE OF CLERK J. H. Harris		44. SIGNATURE OF JURY J. H. Harris		45. SIGNATURE OF JUDGE J. H. Harris	
46. SIGNATURE OF DECEASED J. H. Harris		47. SIGNATURE OF WITNESSES J. H. Harris		48. SIGNATURE OF CLERK J. H. Harris		49. SIGNATURE OF JURY J. H. Harris		50. SIGNATURE OF JUDGE J. H. Harris	
49. SIGNATURE OF DECEASED J. H. Harris		50. SIGNATURE OF WITNESSES J. H. Harris		51. SIGNATURE OF CLERK J. H. Harris		52. SIGNATURE OF JURY J. H. Harris		53. SIGNATURE OF JUDGE J. H. Harris	
54. SIGNATURE OF DECEASED J. H. Harris		55. SIGNATURE OF WITNESSES J. H. Harris		56. SIGNATURE OF CLERK J. H. Harris		57. SIGNATURE OF JURY J. H. Harris		58. SIGNATURE OF JUDGE J. H. Harris	
59. SIGNATURE OF DECEASED J. H. Harris		60. SIGNATURE OF WITNESSES J. H. Harris		61. SIGNATURE OF CLERK J. H. Harris		62. SIGNATURE OF JURY J. H. Harris		63. SIGNATURE OF JUDGE J. H. Harris	
64. SIGNATURE OF DECEASED J. H. Harris		65. SIGNATURE OF WITNESSES J. H. Harris		66. SIGNATURE OF CLERK J. H. Harris		67. SIGNATURE OF JURY J. H. Harris		68. SIGNATURE OF JUDGE J. H. Harris	
69. SIGNATURE OF DECEASED J. H. Harris		70. SIGNATURE OF WITNESSES J. H. Harris		71. SIGNATURE OF CLERK J. H. Harris		72. SIGNATURE OF JURY J. H. Harris		73. SIGNATURE OF JUDGE J. H. Harris	
74. SIGNATURE OF DECEASED J. H. Harris		75. SIGNATURE OF WITNESSES J. H. Harris		76. SIGNATURE OF CLERK J. H. Harris		77. SIGNATURE OF JURY J. H. Harris		78. SIGNATURE OF JUDGE J. H. Harris	
79. SIGNATURE OF DECEASED J. H. Harris		80. SIGNATURE OF WITNESSES J. H. Harris		81. SIGNATURE OF CLERK J. H. Harris		82. SIGNATURE OF JURY J. H. Harris		83. SIGNATURE OF JUDGE J. H. Harris	
84. SIGNATURE OF DECEASED J. H. Harris		85. SIGNATURE OF WITNESSES J. H. Harris		86. SIGNATURE OF CLERK J. H. Harris		87. SIGNATURE OF JURY J. H. Harris		88. SIGNATURE OF JUDGE J. H. Harris	
89. SIGNATURE OF DECEASED J. H. Harris		90. SIGNATURE OF WITNESSES J. H. Harris		91. SIGNATURE OF CLERK J. H. Harris		92. SIGNATURE OF JURY J. H. Harris		93. SIGNATURE OF JUDGE J. H. Harris	
94. SIGNATURE OF DECEASED J. H. Harris		95. SIGNATURE OF WITNESSES J. H. Harris		96. SIGNATURE OF CLERK J. H. Harris		97. SIGNATURE OF JURY J. H. Harris		98. SIGNATURE OF JUDGE J. H. Harris	
99. SIGNATURE OF DECEASED J. H. Harris		100. SIGNATURE OF WITNESSES J. H. Harris		101. SIGNATURE OF CLERK J. H. Harris		102. SIGNATURE OF JURY J. H. Harris		103. SIGNATURE OF JUDGE J. H. Harris	



RECEIVED
JAN 10 1900
BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8024 CERTIFICATE OF DEATH

08002

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>				c. LENGTH OF STAY IN 1b <u>40 yrs.</u> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>B</u> Last <u>Rinehart</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 14, 1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>4</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home Construction</u>			
11. BIRTHPLACE (State or foreign country) <u>Towson, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>			
13. FATHER'S NAME <u>Frederick Rinehart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>213-12-8807</u>		17. INFORMANT Address <u>Mrs., Emma F. Rinehart, Abingdon, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 1, 1958</u> to <u>July 7, 1959</u> , that I last saw the deceased alive on <u>July 7, 1959</u> , and that death occurred at <u>7:38</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air, md</u> DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Balto., Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence J. McCombs</u> ADDRESS <u>Abingdon, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8025

Reg. Dist. No.

08003

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b X Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) US Army Hospital, Aberdeen Proving Ground, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMY Middle JO Last RIST		4. DATE OF DEATH Month July Day 8 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1959
9. AGE (In years last birthday) yrs. —		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days 5 Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Clinton Rist		14. MOTHER'S MAIDEN NAME Betty Rose Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT JOHN C. RIST, Father		Address 11 E Rieder Court, Edgewood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CNS disease, congenital & Pulmonary congestion 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 July , 19 59 , to 8 July , 19 59 , that I last saw the deceased alive on 8 July , 19 59 , and that death occurred at 4:10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas J. Fraher M.D.		US Army Hospital Aberdeen Proving Ground, Md.	
PHYSICIAN'S NAME (Type) THOMAS J. FRAHER, Capt., MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/11/1959	22c. NAME OF CEMETERY OR CREMATORY Post Cemetery	22d. LOCATION (City, town, or county) (State) Army Chemical Center, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John E. Barring		24a. REC'D BY REGISTRAR DATE JUL 13 59	24b. REGISTRAR'S SIGNATURE Arthur L. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050322xv7

10-10-1918

NEW HAMPSHIRE STATE DEPARTMENT OF HEALTH - BATHSORE 10

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color	
John Doe		35		Male		White		White	
Place of Birth		Date of Birth		Date of Death		Time of Death		Place of Death	
New York City		Jan 1, 1883		Jan 15, 1918		10:30 AM		New York City	
Cause of Death		Disease		Duration		Treatment		Remarks	
Pneumonia		Pneumonia		10 days		None		None	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer		Signature of Witness	
J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8026

CERTIFICATE OF DEATH

Reg. Dist. No.

18004

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground				d. STREET ADDRESS 520 North Stokes Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WALTER Middle EDWARD Last ROBINSON				4. DATE OF DEATH Month July Day 27 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1 Jan 1903	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier - Retired		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank E Robinson		14. MOTHER'S MAIDEN NAME Maggie Ramer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II Korean	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clair Robinson		Address 613B Front Street Clearfield, Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured ribs and pneumothorax DUE TO (c) Pulmonary emphysema and alcoholism							INTERVAL BETWEEN ONSET AND DEATH 4 days 6 days unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease with history of failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Unknown		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 July 1959 , to 27 July 1959 , that I last saw the deceased alive on 11:30 AM 27 Jul, 19 59 , and that death occurred at 1:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 27 Jul 59							
ACTUAL SIGNATURE D. Hamaty M.D.				PHYSICIAN'S NAME (Type) D. HAMATY Capt MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removed				22b. DATE THEREOF 7/29/59			
22c. NAME OF CEMETERY OR CREMATORY Bigler Cemetery				22d. LOCATION (City, town, or county) (State) Bigler, Clearfield Co. Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE John E. Harving				ADDRESS Aberdeen Md.			
24a. REC'D BY REGISTRAR DATE JUL 30 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

Name of Deceased [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Usual Residence [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Place of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	
Date of Report [Illegible]		Office of Registrar [Illegible]	

8027 **CERTIFICATE OF DEATH**

08005

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Whiteford</u>		LENGTH OF STAY (in this place) <u>50yrs. +</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Whiteford</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Benjamin Archer Ross</u>				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>9</u> (Year) <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>25 July, 1875</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland, Cecil Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unkn.</u>		16. SOCIAL SECURITY NO. <u>220-01-1796</u>		17. INFORMANT & ADDRESS <u>Mrs. Helen Jones, Whiteford, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422-1 IMMEDIATE CAUSE (A) <u>Lobar pneumonia - bilateral</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute congestive failure</u>						<u>5 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Cardiovascular disease</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 7</u>, 19<u>59</u>, to <u>July 9</u>, 19<u>59</u>, that I last saw the deceased alive on <u>8 July</u>, 19<u>59</u>, and that death occurred at <u>11:20 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edwin W. Whiteford Jr M.D.</u>		DATE THEREOF <u>July 12, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Slate Ridge</u>		LOCATION (City, town, or county) (State) <u>Delta, Penna</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Arthur E. Evans</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Markina</u>		ADDRESS <u>Delta, Penna</u>	
DATE <u>JUL 13 '59</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 TOM

CERTIFICATE OF DEATH

Reg. Dist. No.

1. SEXUAL RESIDENCE (HOME) OF DECEASED

NAME: John J. Smith COUNTY: Harford

CITY: Bellevue TOWN: Bellevue ZIP: 21034

DATE OF DEATH: 10/15/1988 TIME OF DEATH: 10:00 AM

AGE: 65 SEX: M

DATE OF BIRTH: 10/15/1923

PLACE OF BIRTH: Bellevue, Harford Co., Md.

EDUCATION: High School

OCCUPATION: Retired

CAUSE OF DEATH: Heart Disease

IMMEDIATE CAUSE: Myocardial Infarction

INTERMEDIATE CAUSE: Coronary Artery Disease

FINAL CAUSE: Arteriosclerosis

DATE OF EXAMINATION: 10/15/1988

SIGNATURE: John J. Smith

DATE OF SIGNATURE: 10/15/1988

PLACE OF SIGNATURE: Bellevue, Harford Co., Md.

DATE OF DEATH: 10/15/1988

TIME OF DEATH: 10:00 AM

AGE: 65 SEX: M

DATE OF BIRTH: 10/15/1923

PLACE OF BIRTH: Bellevue, Harford Co., Md.

EDUCATION: High School

OCCUPATION: Retired

CAUSE OF DEATH: Heart Disease

IMMEDIATE CAUSE: Myocardial Infarction

INTERMEDIATE CAUSE: Coronary Artery Disease

FINAL CAUSE: Arteriosclerosis

DATE OF EXAMINATION: 10/15/1988

SIGNATURE: John J. Smith

DATE OF SIGNATURE: 10/15/1988

PLACE OF SIGNATURE: Bellevue, Harford Co., Md.

DATE OF DEATH: 10/15/1988

TIME OF DEATH: 10:00 AM

AGE: 65 SEX: M

2. PLACE OF DEATH

NAME: John J. Smith COUNTY: Harford

CITY: Bellevue TOWN: Bellevue ZIP: 21034

DATE OF DEATH: 10/15/1988 TIME OF DEATH: 10:00 AM

AGE: 65 SEX: M

DATE OF BIRTH: 10/15/1923

PLACE OF BIRTH: Bellevue, Harford Co., Md.

EDUCATION: High School

OCCUPATION: Retired

CAUSE OF DEATH: Heart Disease

IMMEDIATE CAUSE: Myocardial Infarction

INTERMEDIATE CAUSE: Coronary Artery Disease

FINAL CAUSE: Arteriosclerosis

DATE OF EXAMINATION: 10/15/1988

SIGNATURE: John J. Smith

DATE OF SIGNATURE: 10/15/1988

PLACE OF SIGNATURE: Bellevue, Harford Co., Md.

DATE OF DEATH: 10/15/1988

TIME OF DEATH: 10:00 AM

AGE: 65 SEX: M

DATE OF BIRTH: 10/15/1923

PLACE OF BIRTH: Bellevue, Harford Co., Md.

EDUCATION: High School

OCCUPATION: Retired

CAUSE OF DEATH: Heart Disease

IMMEDIATE CAUSE: Myocardial Infarction

INTERMEDIATE CAUSE: Coronary Artery Disease

FINAL CAUSE: Arteriosclerosis

DATE OF EXAMINATION: 10/15/1988

SIGNATURE: John J. Smith

DATE OF SIGNATURE: 10/15/1988

PLACE OF SIGNATURE: Bellevue, Harford Co., Md.

DATE OF DEATH: 10/15/1988

TIME OF DEATH: 10:00 AM

AGE: 65 SEX: M

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF HARFORD, MARYLAND. IT IS TO BE RETURNED TO THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN 10 DAYS OF THE DATE OF DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8028

CERTIFICATE OF DEATH

08006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, Aberdeen Proving Ground, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last ST CLAIR		4. DATE OF DEATH Month July Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Engineer		10b. KIND OF BUSINESS OR INDUSTRY US Army	9. AGE (In years last birthday) 59 IF UNDER 1 YEAR: Months 20 Days 19 Hours 59 Min.
11. BIRTHPLACE (State or foreign country) Lansing, Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank St. Clair		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. UNKNOWN #1 213-12-7902	
17. INFORMANT BERTHA ST CLAIR (Wife)		Address 106 A Rodman Rd Aberdeen, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion (History of angina and heart disease) DUE TO disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH 40 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on DOA , 19____, and that death occurred at 1000 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Jerome B. Bryant, Jr. M.D.		US Army Hospital Aberdeen Proving Ground, Maryland	
PHYSICIAN'S NAME (Type) Jerome B. Bryant, Major MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/23/59	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens Bel Air, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarrington		24a. REC'D BY REGISTRAR 24 59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08007

8007 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>5 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>309 ST JOHN ST.</u>				STREET ADDRESS (If rural give location) <u>309 ST. JOHN ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>EDGAR SPEAR SHARER</u>				4. DATE OF DEATH (Month) <u>JULY</u> (Day) <u>11</u> (Year) <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 6 1900</u>		9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FT. GEO. MEADE</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES B. SHARER</u>				14. MOTHER'S MAIDEN NAME <u>DOLLY MAE SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-07-0860</u>		17. INFORMANT & ADDRESS <u>MRS. LEODA E. SHARER</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) DUE TO <u>Pneumonia</u>				<u>Pneumonia</u>		<u>1 hour</u>	
ANTECEDENT CAUSE(S) (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Coronary Occlusion</u>				<u>Coronary Occlusion</u>		<u>1 hour</u>	
(C) <u>Chronic Myocarditis</u>				<u>Chronic Myocarditis</u>		<u>2 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUL 10</u>, 19<u>59</u>, to <u>JUL 11</u>, 19<u>59</u>, that I last saw the deceased alive on <u>JUL 11</u>, 19<u>59</u>, and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Walbert M.D.</u>				ADDRESS (Street, city, town, state) <u>Havre de Grace Md</u> DATE SIGNED <u>JUL 13 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7-14-1959</u>		NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEM.</u>		LOCATION (City, town, or county) (State) <u>CUMBERLAND MD</u>	
24. REC'D BY REGISTRAR DATE <u>JUL 15 '59</u>		REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Havre de Grace, Md.</u>	

DEATH CERTIFICATE

Reg. No. 100

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS

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MASSACHUSETTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8008

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>		d. STREET ADDRESS <u>5913 Karon Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Simpson</u> Last <u>Simpson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1877</u>
9. AGE (In years last birthday) yrs. <u>82</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Schweikart</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Muth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Minnie Horner</u>		Address <u>5913 Karon Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>Chronic Cardio-vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 30</u> , 19 <u>59</u> , to <u>July 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>59</u> , and that death occurred at <u>4:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>July 7, 1959</u>			
ACTUAL SIGNATURE <u>Willard P. Hudson, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/10/59</u>	<u>Baltimore Cemetery</u>	<u>Balt. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony Miller</u>		24. REC'D BY REGISTRAR DATE <u>JUL 9 '59</u>	
ADDRESS <u>2334 Jefferson St.</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Harris</u>	

8009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BELAIR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>1 142 WILLIAMS ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRITZ JENNINGS STERBAK</u>				4. DATE OF DEATH Month Day Year <u>JULY 10 19 59</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/59</u>	9. AGE (In years lost birth day) yrs. <u>1</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRITZ VINCENT STERBAK</u>				14. MOTHER'S MAIDEN NAME <u>AUDREY SCARBOROUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>FRITZ V. STERBAK, BELAIR, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenal insufficiency</u> 277X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>congenital adrenogenital syndrome</u> DUE TO (c) <u>hypoparathyroidism - secondary cause</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>7/10</u> , 19 <u>59</u> , and that death occurred at <u>4:45 PM</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7/10/59</u>							
ACTUAL SIGNATURE <u>Theodore H. Kaiser</u> M.D.							
PHYSICIAN'S NAME (Type) <u>THEODORE H. KAISER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-13-59</u>		<u>BELAIR GARDENS</u>		<u>BELAIR, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Harkins, Delta, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2048181XV4

10-10-10

MAINE STATE DEPARTMENT OF HEALTH - BATHING, 10

CERTIFICATE OF DEATH

10-10-10

<p>1. NAME OF DECEASED <i>John J. Smith</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15, 1865</i></p>	
<p>5. PLACE OF BIRTH <i>Portland, Me.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>Dec 10, 1885</i></p>	
<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>11. MEDICAL HISTORY <i>None</i></p>		<p>12. DATE OF DEATH <i>Oct 10, 1910</i></p>	
<p>13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>14. SIGNATURE OF REGISTRAR <i>Wm. J. Smith</i></p>		<p>15. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>16. SIGNATURE OF WITNESSES <i>John J. Smith</i></p>	

MAINE STATE DEPARTMENT OF HEALTH - BATHING, 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18009

8010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BE LAIR				c. LENGTH OF STAY IN 1b 4 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 REED ST.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 BE LAIR			
				f. STREET ADDRESS 104 REED ST.			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle M. Last STREETT				4. DATE OF DEATH Month JULY Day 6 Year 1959			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 16, 1882	
				9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months 11 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ROCKS, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN A. STREETT				14. MOTHER'S MAIDEN NAME FLORA MITCHELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT ELIZABETH K. STREETT Address 104 REED ST. BE LAIR, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) consequences of the kidney DUE TO prostatic cancer (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 to 1959 , that I last saw the deceased alive on July 5, 1959 , and that death occurred at MD. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 REED ST. BE LAIR, MD. DATE SIGNED 7/15/59 ACTUAL SIGNATURE BENJAMIN DOROST, M. D. M.D. PHYSICIAN'S NAME (Type) Cardiff, Maryland							
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-9-59		22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS		22d. LOCATION (City, town, or county) (State) ROCKS, HARFORD CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hopkins, Delta, Pa. ADDRESS				24a. REC'D BY REGISTRAR JUL 10 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

2010

Form 100-101

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. DATE OF DEATH <i>10/15/2010</i>	
3. PLACE OF DEATH <i>Home</i>		4. COUNTY <i>Baltimore</i>	
5. SEX <i>Male</i>		6. AGE <i>78</i>	
7. RACE <i>White</i>		8. MARITAL STATUS <i>Married</i>	
9. OCCUPATION <i>Retired</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
13. SIGNATURE OF DECEASED <i>John J. Smith</i>		14. SIGNATURE OF WITNESS <i>John J. Smith</i>	
15. SIGNATURE OF DECEASED <i>John J. Smith</i>		16. SIGNATURE OF WITNESS <i>John J. Smith</i>	
17. SIGNATURE OF DECEASED <i>John J. Smith</i>		18. SIGNATURE OF WITNESS <i>John J. Smith</i>	
19. SIGNATURE OF DECEASED <i>John J. Smith</i>		20. SIGNATURE OF WITNESS <i>John J. Smith</i>	
21. SIGNATURE OF DECEASED <i>John J. Smith</i>		22. SIGNATURE OF WITNESS <i>John J. Smith</i>	
23. SIGNATURE OF DECEASED <i>John J. Smith</i>		24. SIGNATURE OF WITNESS <i>John J. Smith</i>	
25. SIGNATURE OF DECEASED <i>John J. Smith</i>		26. SIGNATURE OF WITNESS <i>John J. Smith</i>	
27. SIGNATURE OF DECEASED <i>John J. Smith</i>		28. SIGNATURE OF WITNESS <i>John J. Smith</i>	
29. SIGNATURE OF DECEASED <i>John J. Smith</i>		30. SIGNATURE OF WITNESS <i>John J. Smith</i>	
31. SIGNATURE OF DECEASED <i>John J. Smith</i>		32. SIGNATURE OF WITNESS <i>John J. Smith</i>	
33. SIGNATURE OF DECEASED <i>John J. Smith</i>		34. SIGNATURE OF WITNESS <i>John J. Smith</i>	
35. SIGNATURE OF DECEASED <i>John J. Smith</i>		36. SIGNATURE OF WITNESS <i>John J. Smith</i>	
37. SIGNATURE OF DECEASED <i>John J. Smith</i>		38. SIGNATURE OF WITNESS <i>John J. Smith</i>	
39. SIGNATURE OF DECEASED <i>John J. Smith</i>		40. SIGNATURE OF WITNESS <i>John J. Smith</i>	
41. SIGNATURE OF DECEASED <i>John J. Smith</i>		42. SIGNATURE OF WITNESS <i>John J. Smith</i>	
43. SIGNATURE OF DECEASED <i>John J. Smith</i>		44. SIGNATURE OF WITNESS <i>John J. Smith</i>	
45. SIGNATURE OF DECEASED <i>John J. Smith</i>		46. SIGNATURE OF WITNESS <i>John J. Smith</i>	
47. SIGNATURE OF DECEASED <i>John J. Smith</i>		48. SIGNATURE OF WITNESS <i>John J. Smith</i>	
49. SIGNATURE OF DECEASED <i>John J. Smith</i>		50. SIGNATURE OF WITNESS <i>John J. Smith</i>	
51. SIGNATURE OF DECEASED <i>John J. Smith</i>		52. SIGNATURE OF WITNESS <i>John J. Smith</i>	
53. SIGNATURE OF DECEASED <i>John J. Smith</i>		54. SIGNATURE OF WITNESS <i>John J. Smith</i>	
55. SIGNATURE OF DECEASED <i>John J. Smith</i>		56. SIGNATURE OF WITNESS <i>John J. Smith</i>	
57. SIGNATURE OF DECEASED <i>John J. Smith</i>		58. SIGNATURE OF WITNESS <i>John J. Smith</i>	
59. SIGNATURE OF DECEASED <i>John J. Smith</i>		60. SIGNATURE OF WITNESS <i>John J. Smith</i>	
61. SIGNATURE OF DECEASED <i>John J. Smith</i>		62. SIGNATURE OF WITNESS <i>John J. Smith</i>	
63. SIGNATURE OF DECEASED <i>John J. Smith</i>		64. SIGNATURE OF WITNESS <i>John J. Smith</i>	
65. SIGNATURE OF DECEASED <i>John J. Smith</i>		66. SIGNATURE OF WITNESS <i>John J. Smith</i>	
67. SIGNATURE OF DECEASED <i>John J. Smith</i>		68. SIGNATURE OF WITNESS <i>John J. Smith</i>	
69. SIGNATURE OF DECEASED <i>John J. Smith</i>		70. SIGNATURE OF WITNESS <i>John J. Smith</i>	
71. SIGNATURE OF DECEASED <i>John J. Smith</i>		72. SIGNATURE OF WITNESS <i>John J. Smith</i>	
73. SIGNATURE OF DECEASED <i>John J. Smith</i>		74. SIGNATURE OF WITNESS <i>John J. Smith</i>	
75. SIGNATURE OF DECEASED <i>John J. Smith</i>		76. SIGNATURE OF WITNESS <i>John J. Smith</i>	
77. SIGNATURE OF DECEASED <i>John J. Smith</i>		78. SIGNATURE OF WITNESS <i>John J. Smith</i>	
79. SIGNATURE OF DECEASED <i>John J. Smith</i>		80. SIGNATURE OF WITNESS <i>John J. Smith</i>	
81. SIGNATURE OF DECEASED <i>John J. Smith</i>		82. SIGNATURE OF WITNESS <i>John J. Smith</i>	
83. SIGNATURE OF DECEASED <i>John J. Smith</i>		84. SIGNATURE OF WITNESS <i>John J. Smith</i>	
85. SIGNATURE OF DECEASED <i>John J. Smith</i>		86. SIGNATURE OF WITNESS <i>John J. Smith</i>	
87. SIGNATURE OF DECEASED <i>John J. Smith</i>		88. SIGNATURE OF WITNESS <i>John J. Smith</i>	
89. SIGNATURE OF DECEASED <i>John J. Smith</i>		90. SIGNATURE OF WITNESS <i>John J. Smith</i>	
91. SIGNATURE OF DECEASED <i>John J. Smith</i>		92. SIGNATURE OF WITNESS <i>John J. Smith</i>	
93. SIGNATURE OF DECEASED <i>John J. Smith</i>		94. SIGNATURE OF WITNESS <i>John J. Smith</i>	
95. SIGNATURE OF DECEASED <i>John J. Smith</i>		96. SIGNATURE OF WITNESS <i>John J. Smith</i>	
97. SIGNATURE OF DECEASED <i>John J. Smith</i>		98. SIGNATURE OF WITNESS <i>John J. Smith</i>	
99. SIGNATURE OF DECEASED <i>John J. Smith</i>		100. SIGNATURE OF WITNESS <i>John J. Smith</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8011

CERTIFICATE OF DEATH

Reg. Dist. No.

08011

1. PLACE OF DEATH o. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Chesford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hare de Bree</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chesford Men. Hospital</u>		d. STREET ADDRESS <u>Paradise Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (LAST) <u>Taylor</u> (FIRST) <u>Florence</u> (MIDDLE) <u>Genevieve</u>	4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1909</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>49</u>	IF UNDER 24 HRS. Days <u>21</u> Hours <u>21</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Andrew S. Jessup</u>		14. MOTHER'S MAIDEN NAME <u>Florence Schmiedly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>William C. Taylor</u>	
17. INFORMANT Address <u>Paradise Rd. Aberdeen, Md.</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Rheumatic Heart disease with Mitral Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 week</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July 13</u> , 19 <u>59</u> , to <u>July 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>59</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.		
ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE <u>George W. Sontos</u> M.D. <u>Johns Hopkins Hospital</u>		<u>7/21/59</u>
PHYSICIAN'S NAME (Type) <u>George W. Sontos, M.D.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>
22d. LOCATION (City, town, or county) <u>Perryman, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u> ADDRESS <u>Tarring Funeral Home Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 24 '59</u>
24b. REGISTRAR'S SIGNATURE <u>Charles L. Huns</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8011

NAME OF DECEASED WILLIAM C. TRACY APPENDIX		SEX MALE	
DATE OF BIRTH APR 27 1939		PLACE OF BIRTH BALTIMORE, MD	
DATE OF DEATH MAY 10 1975		PLACE OF DEATH BALTIMORE, MD	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)	
MANNER OF DEATH (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF REGISTRAR [Signature]		OFFICIAL USE ONLY [Stamp]	



This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof is to be furnished to the local health officer of the jurisdiction in which the death occurred.